SUD Support Newsletter

Authority & Quality Improvement Services

October 2021

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UPDATES

- Clarification: For the option to calculate the timelines for Treatment Plan updates, either every 90 calendar days from the admission date or 90 calendar days from the last Treatment Plan, **please note that for either option, you will still need to ensure that the Treatment Plan is only valid for up to 90 calendar days.** This means that even if you are completing your Treatment Plan at Outpatient Drug Free (ODF) within 90

...continued on page 2

WHAT'S NEW?

Are you familiar with what the Department of Health Care Services' (DHCS) Information Notices are? These documents are provided by the State to alert counties of changes in policy or procedures at the Federal or State levels. These Information Notices are primarily directed at the counties. We have been reviewing the information that is pertinent to the Drug Medi-Cal Organized Delivery System (DMC-ODS) in the Quality Improvement Coordinators' meetings that are held monthly to discuss how it is applicable to our system. However, you as a provider can access the State's Information Notices at any time here: https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx

Please note, that the State also releases Information Notices relevant for other programs and funding sources besides Substance Use Disorder Treatment, such as for Mental Health. As a result, not all of it will apply to the DMC-ODS. If you are unsure whether a particular Information Notice is applicable to your program or have questions, feel free to reach out to us at AQISSUDSupport@ochca.com

Documentation Training

SST SUD Documentation Training (online): https://www1.ochca.com/ochealthinfo.com/training/bhs/aqis/SUDDocumentationTraining/story.html

The SUD Case Management Training: https://www.ochealthinfo.com/about-hca/behavioral-health-services/bh-services/drug-medi-cal-organized-delivery-system-dmc-ods

Test Your DMC-ODS Knowledge!

What are the different types of billable services in the DMC-ODS?

a. Assessment, Treatment Planning, Discharge Planning, Groups
b. Individual Counseling, Group Counseling, Case Management
c. Anything SUD-related

…UPDATES (continued)

…continued from page 1

calendar days from the client's admission, you will still need to be mindful of the actual effective date of that Treatment Plan, so that the next Treatment Plan update can be completed within the next 90 calendar days.

For example, if the initial Treatment Plan at ODF is completed on day 25 (within 30 calendar days of admission) and you plan on using the timeline from admission, the next Treatment Plan update would be due by day 90. However, if you complete that Treatment Plan update at day 85, then your subsequent Treatment Plan will be due within 90 days of that Treatment Plan update (by day 175). This ensures that the Treatment Plan update created on day 85 is only valid for up to 90 calendar days. If the subsequent Treatment Plan is unable to be created until day 180, this means that any services provided between day 176 and 179 must be made non-compliant because a Treatment Plan cannot be valid for more than 90 calendar days.

We understand that timelines are difficult to adhere to, amidst all of the other requirements. At minimum, please ensure that services being claimed are supported by a valid Treatment Plan that has only been in effect for a maximum of 90 calendar days. Any services provided in between Treatment Plans that have exceeded the 90 calendar days should be entered in the billing system as a non-complaint service.

Documentation FAQ

1. I heard that the State's COVID-19 flexibilities have expired. Can I still provide services via telephone and telehealth?

Yes. The State is continuing to allow for the provision of services via telephone and telehealth, as clinically appropriate, through December 31, 2022. Telephone and telehealth are just modes by which services are provided. The service you provide via telephone or telehealth is equivalent to what would have been provided in-person. Please be sure for telehealth, to continue to document the reason the service is being provided in this format, document the client's consent for receiving the telehealth service, document how you ensured confidentiality, and document that you confirmed the client is present in the state of California. Don't forget to add the GT modifier to your claim to avoid denials and delays.

2. My client at Residential is stepping down to Intensive Outpatient Treatment (IOT). The client is scheduled for an intake at the IOT on 10/13/21, while they are still at Residential. Can we bill at Residential for 10/13/21?

…continued on page 3

SST Clinical Chart Review Findings & Trends

The SST QI Consultants have started visiting provider sites to conduct Clinical Chart Reviews for fiscal year 2021-2022. Some common recoupment issues we have been seeing that we all need to be careful about…

- Not addressing the 10 psychosocial elements in the Initial Assessment
    - Remember, if you have multiple levels of care at your site and use the SUD Re-Assessment as the Initial Assessment, it needs to include the 10 elements or reference the assessment document that contains the information. Missing 1 of the 10 will, unfortunately, result in recoupment of all services based on that assessment.
- Not authorizing all types of services to be provided on the Treatment Plan
    - Be explicit in identifying the type of service and the frequency that it will be provided. A service that is being provided consistently without an authorization on the Treatment Plan will result in recoupment of all instances where that service was claimed under that Treatment Plan.

If you have questions or need clarification, please be sure to ask your designated SST QI Consultant!

Documentation FAQ (continued)

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Not if the IOT is going to bill for the intake/assessment on the same day. The State would view this as duplicate billing or the billing of the same type of service on the same day. Remember that the Residential program bills for a treatment day (which covers all clinical services like individual and group counseling). An intake or assessment session at IOT is considered an individual counseling service. Therefore, both the Residential service and the IOT service cannot be billed on the same day. If you are coordinating the transition for your client to go from your program to another, be sure to coordinate who is going to bill. Either the Residential or the IOT can bill the individual counseling, although it makes the most sense to have the IOT claim the intake/assessment as the client will be continuing services with that provider. The other provider could always bill case management on the same day instead.

3. I'm the LPHA. Why can't I just write, "The client meets medical necessity based on ASAM Criteria" and co-sign the non-LPHA's assessment as my "documentation of medical necessity?"

"Medical Necessity Criteria" means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria (Page 157 of the Intergovernmental Agreement (IA)). There is a specific way in which this needs to be documented, according to the State. Page 138 of the IA: "The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record…" and "The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary's assessment and intake information, including their personal, medical, and substance use history." If you are a medical professional who qualifies as an LPHA, it is also important to remember the following: The State defines "ASAM Criteria-Medical Necessity" as "pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Clinical Necessity," "necessity of care," or "clinical appropriateness" (Page 149 of the IA).

Who Needs to Document???

Preliminary diagnosis consultation between the non-LPHA and LPHA:

What this is NOT… This consultation is distinct from the medical necessity consultation after the non-LPHA completes the assessment so that the LPHA can use the information obtained to establish a diagnosis and the ASAM Criteria for the level of care.

What is possible? Both the non-LPHA and LPHA can document and bill for the time as a Case Management service, as long as the start and end time for the consultation matches.

What is required? Since only the LPHA is allowed to diagnose in the DMC-ODS, at minimum, if only one person documents, it needs to be the LPHA!! It is the LPHA's documentation that will provide his/her/their attestation that it was, indeed, the LPHA who is determining the preliminary diagnosis.

Reminders

For Youth Clients:

Don't forget to follow the Youth Treatment Guidelines! Some areas of consideration that can impact a client's substance use and/or recovery include, but are not limited to: academic/school performance, interpersonal relationships (peer pressure, defiance towards authority).

Change in Level of Care within the Same Entity:

Don't forget to properly open and close the episode of care (EOC) in the billing system (IRIS) and use the right code. For example, if your client is going from IOT to ODF, be sure to close the EOC for IOT and open a new EOC at ODF. Then, code your services using the ODF codes after the EOC start date at ODF.

Corrections in the billing system (IRIS):

For office support staff making any changes to claims made in IRIS, such as changing the code of the service, correcting the service/documentation time claimed, etc. you have the wonderful BHS Front Office Coordination Team to assist you!

bhsirisfrontofficesupport@ochca.com

(714) 834-6007

"Test Your DMC-ODS Knowledge" Answer: b

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

- GRIEVANCES & INVESTIGATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- CLINICAL SUPERVISION
- PAVE ENROLLMENT FOR COUNTY SUD DMC-ODS CLINICS & PROVIDERS
- CREDENTIALING
- ACCESS LOGS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP)
- MHP/SUD DMC-ODS PROVIDER DIRECTORIES
- PAVE ENROLLMENT FOR MHP PROVIDERS

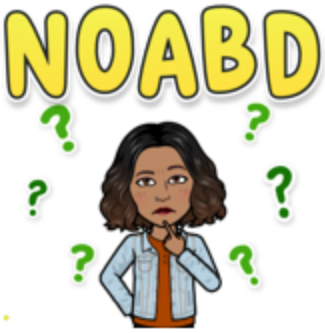
REMINDERS

ACCESS LOGS

- An Access Log entry is required each time a **NEW** beneficiary enters our provider network and requests services. This access log entry is created through the use of the Access Log form accessed in IRIS by the provider receiving the beneficiary's service request.
- The Access Log provides data that measures beneficiaries' access to SUD and MHP services. It is from this access log entry that the network can describe the number of days between a beneficiary's request for services, the date of the initial appointment, the number of days until the service was actually delivered to the beneficiary and whether or not a Timely Access NOABD should be issued.
- MCST will be developing a more streamlined process to monitor programs more closely to ensure compliance with DHCS requirements to track Access Log entries.
- The only exception to creating an Access Log occurs when the beneficiary is scheduled by the Beneficiary Access Line (BAL) or 24/7 Behavioral Health Access Line to your program. In such case, the BAL or 24/7 Behavioral Health Access Line, gathers the same access log data from the beneficiary during the beneficiary's telephone call with them.

NOABD - BENEFICIARY REQUESTING AN APPEAL

- Under federal regulations, an NOABD "Appeal" is a review by the Plan of an Adverse Benefit Determination.
- Federal regulations require beneficiaries to file an appeal within 60 calendar days from the date of when the NOABD was issued.



- When the beneficiary files an NOABD "Appeal" the MCST is required to open an investigation and resolve it within 30 calendar days.
- The program is also required to assist the beneficiary with the continuation of benefits during an appeal of the adverse benefit determination in accordance with federal regulations. This means, the program must keep the case open and continue to provide services until the investigation has been upheld or overturned.
- Refer to DHCS MHSUDS Information Notice #18-010E: https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf

MANAGED CARE SUPPORT TEAM

REMINDERS (CONTINUED)

PROVIDER DIRECTORY

- All Medi-Cal Certified Sites are required to provide an updated provider list to MCST **every month by the 15th**. We ask that you also cc: IRIS (BHSIRISLiaisonTeam@ochca.com) on the monthly submission beginning 11/1/21.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- If you and your staff would like a specific or a full training about MCST's oversight and updates on the State and Federal regulations governing Managed Care please e-mail the Program Manager, Annette Tran at anntran@ochca.com.

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
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CREDENTIALING AND PROVIDER DIRECTORY
Lead: Elaine Estrada, LCSW

ACCESS LOGS
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